Asthma Start Handbook

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Alameda County Public Health Department

Asthma Start Case Management Model

Referral Sources
Children's Hospital
Community Clinics
Health Plans
Public Health Nursing
Other

→ **Referral Form** sent to Asthma Start →

Screening
Asthma Coordinator screens referral for program eligibility

↓

Child admitted to program

First Visit: Forms Used

Consent Form + Initial Assessment Form + Home Assessment Form + Tracking Form + Service Plan

↓

Follow-up Visits: Forms used → **Child Care and Medical Visits** (if appropriate)

Tracking Form + Service Plan → Tracking Form

↓

Final Visit

Final Assessment Form + Home Assessment Form

↓

Post Program Phone Survey

Selected questions from Final Assessment

05/09/01

Asthma Start Handbook

GOALS

The goals of the Asthma Start project are

- strengthen existing collaborations to coordinate/ improve asthma services in Oakland
- improve overall health of young children with asthma and their families
- improve health care treatment and patient/ family education regarding asthma
- conduct an evaluation of community-specific activities and health outcomes

ASTHMA CASE MANAGEMENT

The primary goal of asthma case management is to increase the ability of participating families to manage childhood asthma in collaboration with a regular health care provider and increased access to community based resources. Asthma Coordinators assist families to gain the necessary knowledge, skills and support services to achieve success in asthma self-management through a minimum 3 month program of home visits.

The aim of the asthma case management program is to assist families to attain the knowledge and skills needed for effective self-management of childhood asthma. This is accomplished through the provision of comprehensive services including:

- Adoption of an Asthma Management Plan,
- Appropriate medications, and equipment such as peak flow meters and spacers.
- Implementation of a step-by-step service plan developed in partnership with family participants
- Reduction of triggers
- Working with and advocating for the family to ensure access to medical and supportive services, including health insurance and a primary care provider.

CASE MANAGEMENT PROCEDURES

I. REFERRALS

Procedure:

1. When a family is referred to the Asthma Start Program, the program manager will review the referral form (appendix A) and forward to an Asthma Coordinator if appropriate. The Asthma Coordinator will set up a screening interview performed over the phone within 3 work days of receiving the referral. This screening will determine eligibility for program and at the same time allow the Asthma Coordinator to inform the family about the benefits of the program. The screening questions are located at the bottom of the referral form.

II. SCREENING PROCESS

Asthma Coordinators will screen all referrals to the program to ensure that they meet state guidelines for the Asthma Start grant. Screening questions are identified in shorthand at the bottom right of the referral form (Appendix A). The key components for eligibility are

- child must be under age 5,
- child must have persistent asthma

Age is to be verified by date of birth.

Persistent asthma can be verified by one of the following means
- Persistent asthma diagnosis from a medical provider
- Regular use of 2 asthma medications – controller, steroid and quick relief albuterol
- Frequent use of quick relief medication – albuterol – in excess of 4 times per week
- Hospitalization or Emergency Room visit for asthma in last month

Any child meeting the age requirement and at least one of the persistent asthma requirements is eligible for the program.

If the child is admitted to the program then, the Asthma Coordinator will schedule a time for the Initial Visit during the screening conversation.

Forms used: Referral Form (Appendix A)

III. INITIAL VISIT

An Asthma Coordinator will conduct the Initial visit interview. The interview may be conducted in the prospective family's home, in the program office, or any other agreed upon location. Evening or weekend hours should be available for families who are unable to schedule appointments during business hours.

Initial Visit should be scheduled during the screening call with the family.

The Asthma Coordinator conducting the Initial Visit interview will explain the following:
- Program Overview
- Program Eligibility
- Family Rights and Responsibilities
- Scope of services available

At the Initial Visit, families will be provided with the following documents:
- Program Contact Numbers

Procedure:
1. The Asthma Coordinator will discuss the program with the family and answer any questions. Staff will inform the family about the need to collect information about the family and the child, and will discuss the program's confidentiality policy with the family. Staff will discuss the family's rights and responsibilities in the program, and will ask the parent/guardian to sign the Consent Form.

2. The Asthma Coordinator will discuss the child's asthma history and family concerns with the family.
3. The Asthma Coordinator will conduct an Initial Visit interview with the family and complete all forms thoroughly. Whenever needed the Asthma Coordinator will ask for clarification from the family to ensure accurate responses. These forms are used to measure baseline for knowledge, attitudes, behaviors and health. Comparing the family's answers to the Interview questions at the Initial Visit and answers to these same questions at the Final Visit will allow Asthma Start to show the effectiveness of the intervention.

Forms used: Consent Form (Appendix B)
Registration Form (Appendix C)
State Interview Form (Appendix D)
Asthma Start Additional Interview Form (Appendix E)
Home Assessment (Appendix F)
In-Home Recommendation Follow-Up (Appendix G)
Tracking Form (Appendix H)
Family Goals Worksheet (Appendix I)

IV. BASIC ASTHMA EDUCATION

The goal of asthma education activities is to educate families about asthma, asthma triggers, and strategies for asthma management, including medications, equipment, and asthma management plan. Asthma education is integrated into the program as part of the home visiting intervention

A basic asthma education session should include information about the following topics:

- What happens to the airways during an asthma episode (inflammation, muscle constriction and mucus production)
- Quick Relief Medications
- Preventive Medications
- Asthma Action Plan
- Abnormally sensitive airways (hyper-reactive airways)
- Reversibility of asthma's effects on airways
- Asthma as a chronic condition
- Equipment – spacers and inhalers
- Asthma Triggers

Return demonstrations by family members, including children, will be encouraged to assess skill level in use of equipment.

Asthma Education with Child

A home visit will be conducted to implement educational activities for the child(ren) with asthma and must be scheduled during a time when the child is available. The AC will cover the following areas with the child and family:

- Age appropriate instruction on equipment use

- Review of the use of the Asthma Action Plan with the parents and child if appropriate
- Review of symptom monitoring with the parent

Procedure:

1. The Asthma Coordinator will distribute age appropriate materials for children with illustrative pictures of the lungs. Other hands-on materials may be used to demonstrate how the lungs work. Where appropriate, educational videos maybe used, such as A is for Asthma Sesame Street (for pre-school children).
2. The Asthma Coordinator will assist the child to demonstrate what he/she has learned about asthma (e.g. drawing the lungs, play activity, talking about asthma, as age appropriate)
3. The AC will assist the child to demonstrate his/her understanding and skill in the use of a spacer, Asthma Symptom Diary or Personal Best Diary as appropriate for his/her age.
4. The AC will review the Asthma Action Plan with the child, if the child is old enough to participate in a discussion. If the child has no Asthma Action Plan, this activity should be completed once the child's doctor has filled out the. form.
5. The AC will review the Asthma Symptom Diary or Personal Best Diary with parent to see if there have been any changes and to assess correct use of document.

Form used: Tracking Form (Appendix H)

V. HOME ASSESSMENT

A Home Assessment is performed as part of the first visit, or if there is insufficient time the home assessment can be performed at the next follow-up visit. Working in partnership with the family, the Asthma Coordinator assesses the home environment for sources of indoor allergens or irritants that may make their child's asthma worse. The Asthma Coordinator and family participants then develop and implement a plan to reduce the child's exposure to these asthma triggers in the home. Families are given a copy of the home environmental assessment along with appropriate education and supplies. In order to encourage the family's success in reducing or removing allergens and irritants, the Asthma Coordinator will follow-up on the recommendations of the assessment at each visit and will perform a final assessment at the final visit.

Respecting the family and their efforts at housekeeping are an essential part of making the Home Assessment a useful and integral part of case management. All items should be discussed with the family to explain the importance of each to reducing triggers that exacerbate the child's asthma. When performing the assessment do not enter rooms or open anything unless given permission by an adult family member. Although the home assessment is designed to help families we are only performing an assessment with their permission. Do not put your hands inside or under anything where you can not clearly see.

After completing the assessment the Asthma Coordinator will prioritize 3 – 5 items with the family to work on together. Copy the results of the Home Assessment onto the tracking form for ease in following up at future visits. The original Home Assessment Form stays with the family.

The Home Assessment provides a baseline of environmental risks to which the child is exposed. A final home assessment at the last visit will be performed to identify areas in which the family has improved or will need to continue efforts.

Equipment and supplies will be distributed to families based on needs identified during the Home Assessment. For example, if Dust or Animals are identified as an issue the Asthma Coordinator may recommend distributing a HEPA vacuum cleaner, as well as mattress and pillow covers. If Mold is identified as an issue, the Asthma Coordinator may recommend distributing caulking or mild detergent. If Pests are identified as an issue, the Asthma Coordinator may recommend caulking, air-tight food containers and HEPA vacuum cleaner.

Forms used: Home Assessment (Appendix F)
In-Home Recommendation Follow-Up (Appendix G)

VI. GOALS

By the end of the second visit, the Asthma Coordinator will have worked with the family to develop a Family Goals Worksheet. The Family Goals Worksheet assists the Asthma Coordinator and the family to identify the family's needs and the goals that will be Jointly worked on during the family's participation in the program. The Family Goals Worksheet should be developed through joint discussion between the Asthma Coordinator and the family, and the goals should reflect the family's needs and concerns as well as the program objectives.

Procedure:

I . The AC will explain the purpose of the Family Goals Worksheet to the family.
2. Guided by the family's responses to the initial Assessment and the Home Environmental Assessment, the AC and the family will work together to identify the family's needs and concerns.
3. The AC and the family will work together to develop a step-by-step plan to address the family's needs.
4. The AC will assist the family to set goals that can reasonably be achieved during the family's participation in the program.
5. The AC and the family will work together to assign responsibility for implementing the steps of the Family Goals Worksheet.
6. At each additional home visit, the AC and the family will review the Family Goals Worksheet, assess progress toward the goals identified and barriers or obstacles to progress, and update the plan as needed.

Forms used: Family Goals Worksheet (Appendix I)

VII. REFERRAL FOR SPECIAL SERVICES

At any time during a family's participation in the case management program, the Asthma Coordinator may make a referral for specialized services that the Asthma Start Program is unable to provide directly (e.g. legal assistance, immigration counseling, mental health counseling, domestic violence or child abuse prevention).

Referrals should be discussed with the family and several different agencies or providers should be offered as resources when possible. The AC will utilize a Resource File or Directory that is kept up to date through personal contact with community based programs and agencies. To ensure that the referral meets the family's needs, the AC should call the agency to which the referral is being made both to initiate and follow-up on the referral. Some families may need additional support such as translation or accompaniment to access supportive services.

Procedure:

1. The AC will maintain a current Resource File or Directory of community-based resources and, whenever possible, will make personal contact with agencies and programs in the community to which referrals are being made.
2. The AC will work with the family to identify ongoing needs and determine what specialized asthma services would be useful for that family.
3. The AC will assist the family, if necessary, to make an appointment with the agency or program to which a referral is being made.
4. The AC will complete the agency's referral form with the family and make sure that it is faxed or mailed to the agency.
5. The AC will provide support as needed (such as translation or accompaniment) to help the family access specialized services.
7. The AC will follow-up with both the service provider and the family to ensure that the referral is meeting the family's needs, advocating on behalf of the family when necessary.

Forms used: Progress Notes (Appendix J)

VIII. ADDITIONAL HOME VISITS

The AC will conduct a series of additional home visits to follow-up on basic asthma management and education as well as to ensure access to a variety of supportive services. These visits should be scheduled as appropriate to meet each family's needs and the program objectives.

Additional home visits are scheduled to support the family in achieving the goals agreed upon in the Family Goals Worksheet. Referrals for specialized services may also be made at this time.

Procedure:

1. The Asthma Coordinator will review the Family Goals Worksheet with the family and develop an appropriate schedule of additional visits.
2. Additional visits may be scheduled weekly, bi-weekly or monthly depending on the needs of each family.

Forms completed at additional visit: In-Home Recommendation Follow-Up (Appendix G)
Tracking Form (Appendix H)
Family Goals Worksheet (Appendix I)
Progress Notes (Appendix J)

Home Assessment (Appendix F) **[if not completed at initial visit]**

IX. VISITS TO CHILD CARE AND MEDICAL PROVIDERS

The Asthma Coordinator will set up visits with child care providers and medical providers based on whether the child is attending child care and has a regular medical provider as well as needs expressed during the Initial Interview. The Asthma Coordinator's visits to child care and medical providers must be tracked on the Tracking Form at the bottom. If no visit is performed, indicate the reason why. These visits should be written into the Family Goals Worksheet activities with the family. Both Asthma Coordinator and family members should be clear as to the reason for the Asthma Coordinator visiting providers.

Form used: Tracking Form (Appendix H)
Family Goals Worksheet (Appendix I)

X. FINAL VISIT/ Graduation from Program

The Asthma Coordinator and the family will assess the family's readiness for graduation from the program based on achieving success in asthma self management. This will be determined by the following criteria.

Child's asthma is under control as shown by

- No hospitalizations or emergency department visits for asthma in three months
- No child care absences due to asthma in the past month.
- Child has one specific asthma doctor (primary care or specialist).
- Child has medical insurance, or application has been submitted.
- Child has an Asthma Action Plan filled out by the child's asthma doctor.
- Child has appropriate preventive medications and takes them appropriately.
- Child has, and knows how to use, a peak flow meter and spacer (age appropriate).
- Family has reduced indoor asthma triggers as appropriate.
- Family has become self reliant in accessing needed supportive services

Procedure:

1. The Asthma Coordinator and the family will discuss the family's readiness to graduate from the program.
4. The Asthma Coordinator and the family will review the family's participation in the program to highlight the family's success in asthma self-management including : decreased asthma symptoms, fewer school absences, emergency department visits and hospitalizations, progress in eliminating indoor triggers, and progress in following an appropriate medical regimen.
5. The Asthma Coordinator and the family will discuss support service referrals and, when necessary, will identify a local social service provider for ongoing case management and intervention.
4. The Asthma Coordinator may give the parents and the children graduation certificates and will inform the family of future activities in which the family can become involved such as peer education, social activities, graduation ceremonies, etc.

5. The Asthma Coordinator will ask the family for feedback on how the program could better serve families of children with asthma.

Forms used at Final Visit: State Interview Form (Appendix D)
Asthma Start Additional Interview Form (Appendix E)
Home Assessment Form (Appendix F)

XI. CASE CLOSING

Request for Case Closing

Requests for case closing will be presented at weekly supervision. The AC will ensure that the case file chart is completed and updated and include a case closing form that describes why the case should be closed. The Request for Case Closing form will be submitted along with the case file to the Project Director, who will review the case closing request and approve it.

Procedure:

1. The AC will fill out the Request for Case Closing form, listing the names and dates of birth of the children with asthma who received program services and the date when the case was closed (the last visit date).
2. AC will check off the reason for case closing and provide further details in the comments section of the form. Reasons for case closing may include the following:

- Completed program
- Relocated
- Voluntary departure
- Death
- Other_____

3. The Project Director will review the case file, following the procedures for Chart Audits. If the case file is incomplete, the file will be returned to the AC for review and update. Within one week the AC will re-submit the file for review and closing.

When the case file is complete, the Project Director will sign-off on the Case Closing Form and file the chart as "closed".

Form used for case closing: Case Closing Form (Appendix K)

XII. CASE CONFERENCE

Case Conferences are held weekly as part of case management services. Case Conferences are attended by all team members, including:

During the case conference the following areas are reviewed:

- New Initial Visits - The AC or will describe all new cases opened during the previous week, giving a summary of the family including child's medical history, housing, social services and medical needs.

- Crisis Cases - The AC will describe any case in which a family crisis has been identified (i.e., domestic violence, housing issues
- Assessments - The AC will present and review findings from the Home Environmental Assessment and Remediation plan, and the Family Needs Assessment as appropriate. The team will provide suggestions for the development of a Family Goals Worksheet.
- Follow-up Home Visits - The AC will share information with the team about the current home visit status of his/her caseload.
- Case Closing - The AC will present cases to be closed, discussing services provided, a medical or other provider update, review of school attendance and the family's success in achieving agreed upon program goals.

XIII. CHART AUDIT

Chart Audits will be conducted through a selection process (e.g. every tenth chart). The Program Director will conduct monthly audits to assess accuracy and thoroughness of documentation, to ensure that the protocol is being followed, and to identify any outstanding issues for either training of the AC, or provision of services to the family. Chart Audits review the following areas:

For example: If the service plan identifies the goal of reducing exposure to indoor triggers such as pets, cigarette smoke and old carpeting - the Tracking Form and Case Notes should reflect work done with the family to:

- Address smoking (either out of house/apt.)
- Removal or restriction of pet in house
- Removal or cleaning of carpeting at least once a week.

In addition, the Program Director will contact at least one of the families whose chart was audited (per month, per (AC) to determine if the chart reflects the family's understanding and experience of the AC intervention. This may be done by phone or through a home visit.

XIV FOLLOW-UP PHONE SURVEY

A selection of questions from the Final Assessment will be used to identify what behaviors and knowledge have been sustained beyond the program intervention period. Phone Survey follow-up will be completed every 3 months after the family leaves the program. The Asthma Coordinator will attempt phone contact with the family, a minimum of 3 times.

Appendix A

Referral

A medical provider who is requesting services from Asthma Start Coordinators should fill out referral forms. WIC, Head Start or other professionals may also fill them out.

In the event that an Asthma Coordinator is at a referral site and is introduced to a family the AC can fill out the referral form. Be sure to determine whether the child really has persistent asthma and is younger than 4 years 11 months.

The forms are faxed or given to the program director who reviews them and then assigns them to an AC. The AC should call them within 3 working days and schedule an appointment at that time.

Asthma Coordinator will use the referral forms received by the program to screen families for eligibility. Asthma coordinators will use the box in lower right corner and follow screening procedures outlined in handbook (section II).

Alameda County Asthma Start Referral

For Referral Agency Use:

Referred by
- ☐ Children's Hospital Oakland
- ☐ West Oakland Health Center
- ☐ Alameda Alliance for Health
- ☐ Private Provider
- ☐ Blue Cross Managed Care
- ☐ Every Child Counts
- ☐ Other Clinic
- ☐ Other (specify)_____

Completed by_____ Phone_____

☐ Asthma Start brochure provided to client

About Us: Asthma Start provides free asthma education, asthma risk assessments and linkages to resources to prevent further asthma episodes. Our goal is to improve the health and quality of life of children with asthma. Our program can be contacted at (510) 577-7082

Eligibility

Asthma Start currently provides services to children who meet all of the following criteria:

☐ Under age 5
☐ Has persistent asthma
☐ Lives in East or West Oakland

Child's Name _____, _____ ____/____/____
Last Name First, Middle Initial Date of Birth

Parent/ Guardian _____, _____ _____
Last Name First, Middle Initial Relationship to Child

Street Address _____ Apt # _____

City _____ Zip Code _____

Primary language? _____

Contact Information

Home Phone (_____)_____ Cell Phone (_____)_____

Work Phone (_____)_____ Pager (_____)_____

Does child have an asthma diagnosis? ☐ Yes ☐ No

If yes, what diagnosis? ☐ Severe Persistent ☐ Moderate Persistent ☐ Mild Persistent ☐ Mild Intermittent **☐Not certain**

Who made this diagnosis? _____
Provider's name, address

For office use only

Asthma Diagnosis	☐
Medication Use	☐
Recent Symptoms	☐
Age	☐

Admitted to Program
☐ Yes ☐ No

Please fax completed form to (510) 383-5188

or mail completed form to:

Attn: Paul Cummings
Asthma Start
7200Bancroft Ave. #202
Oakland, Ca 94605

07/10/01

Appendix B

Consent to Release Information Form

The Consent to Release Information form allows Asthma Start to share client information with other agencies. All consent forms should identify Alameda County Lead Poisoning Prevention Program, Alameda County Children and Families Commission, Children's Hospital Oakland, and the California State Asthma Initiative. If the family has an established medical provider their name should be added. If there are other professionals working with the family that the Asthma Coordinator feels they may wish to talk to about the client, their name should be added under other. This form should be completed at the first visit. The parent initials the line next to each entity s/he is giving us permission to share information with. The parent is also to sign their full name at the bottom of the form. The Asthma Coordinator will serve as witness. If they refuse to sign the release form, they will still receive Asthma Start services. Caregiver is to receive a copy of this form.

If a family chooses a new medical provider a new release form should be created and signed by the caregiver. If there are other new professionals in their life e.g. housing rights lawyers we should get them to sign a new release form.

For more informal interactions a verbal agreement by the parent/guardian to talk to someone about their child's asthma is permissible. This verbal agreement should be noted in the progress notes. For example if a neighbor is at the house when you are there for a visit and the parent suggests the neighbor stay because sometimes they baby-sit for the child. A release does not need to be signed by the parent to allow you to talk to the neighbor. You should always ask the parent if it is OK to talk in front of the third party and then note it in the progress notes.

If the parent asks questions about the consent form, explain that Asthma Start does not have any regulatory or enforcement authority. Our program is here to provide assistance and support; we are asking to share information with other agencies that are part of the larger team working on asthma.

If there is a situation that is unclear please consult with program director.

Alameda County Health Care Services Agency
Asthma Start
Eastmont Town Center
7200 Bancroft Ave., Suite 202
Oakland, Ca 94605

REQUEST FOR AND/OR CONSENT FOR RELEASE OF INFORMATION

_____ _____
Client's Name Date of Birth

I hereby authorize release/exchange of information pertinent to the client named above and his/her family to the following agency and or persons named below for the purposes of coordinating/collaborating care.

I have placed my initials next to the names of each agency with which you have my permission to exchange information.

___Alameda County Lead Poisoning Prevention Program
___Alameda County Children and Families Commission
___Children's Hospital Oakland
___California State Asthma Initiative
___Medical Provider/Clinic:_____Phone_____
Address:_____

___Other (please Specify)_____Phone_____
Adress:_____
___Other (please Specify)_____Phone_____
Adress:_____
___Other (please Specify)_____Phone_____
Adress:_____

I understand that I do not have to sign this document and that if I do not sign it, I will continue to receive services from the Alameda County Public Health Department.

This Authorization shall be valid for one (1) year from date of signature or until revoked in writing prior to that date. A photocopy of this form shall be as valid as the original. I understand that I am to receive a copy of this authorization.

_____ _____
Signature of Client/Parent/Guardian Date

_____ _____
Signature of Witness Date

.Alameda County Health Care Services Agency
Asthma Start
Eastmont Town Center
7200 Bancroft Ave., Suite 202
Oakland, CA 94605

Solicite para y/o para el consentimiento para la liberación de información

_____ _____
Nombre del cliente Fecha de nacimiento

Yo por el presente autorizo la liberación / cambio de información pertinente al cliente y de su familia a las agencias siguientes y o las personas denominadas abajo para los propósitos de coordina / colabora el cuidado.

He colocado mis iniciales luego a los nombres de cada agencia con que usted tiene mi permiso para cambiar información.

__Alameda County Lead Poisoning Prevention Program (El Condado de Alameda Prevención de Avenimiento de Plomo)
__Alameda County Children and Families Comission (Comisión del Condado de Alameda de Niños y Familias)
__Children's Hospital Oakland (El Hospital de niños Oakland)
__California State Asthma Initiative (La Iniciativa del Asma del Estado de California)
__Medical Provider/Clinic (Médico/Clinica)_____teléfono_____
La dirección: _____
__Otro (especifica por favor)_____telélefono_____
La dirección: _____
__Otro (especifica por favor)_____teléfono_____
La dirección: _____teléfono_____
__Otro (especifica por favor)_____teléfono_____
La dirección: _____

Entiendo que yo no tengo que firmar este documento y eso si yo no lo firmo, continuaré recibir los servicios del Condado de Alameda el Departamento Público de la Salud.

Esta Autorización será válida para un (1) año de la fecha de firma o hasta que sea escrito antes de esa fecha. Una fotocopia de esta forma será tan válida como la original. Entiendo que deberé recibir una copia de esta autorización.

_____ _____
La firma de Cliente/ Padre/ Guardián Fecha

_____ _____
La firma de testigo Fecha

Appendix C

Registration Form

This form should be done at the first session. It is important to get the number of an emergency contact. Ask for someone who is stable and does not change his or her phone number often. You can explain that this is to help locate them if you get out of contact. This is also in case there is any sort of emergency when you are at their home.

Case #_____
For office use only

Asthma Start Registration Form

___/___/___
Today's date

Child's Name _____, _____ Date of Birth ___/___/___
Last, First, Middle Initial MM DD YY

Social Security Number __ __ __-__ __-__ __ __ __ _____
Place of Birth

Parent/ Guardian _____, _____ _____
Last Name First, Middle Initial Relationship to Child

Parent/ Guardian _____, _____ _____
Last Name First, Middle Initial Relationship to Child

Contact Information

Street Address _____ Apt # _____

City _____ Zip Code _____

Home Phone (_____)_____ Cell Phone (_____)_____

Work Phone (_____)_____ Pager (_____)_____

Medical Provider
Does your child have a regular doctor? ☐ Yes ☐ No

Doctor's Name _____

Doctor's Phone (____) _____

Child Care
Does your child attend day care? ☐Yes ☐ No

Contact person: _____

Address of day care? _____

Phone number? (____)_____

Does your child care provider administer asthma medication to your child? ☐Yes ☐ No

may we contact your child care provider? ☐Yes ☐ No

Emergency Contact:

_____ (____)_____
Name Phone Number

Case #_____
For office use only

Asthma Start Registration Form

___/___/___
Today's date

Child's Name _____, _____ Date of Birth ___/___/___
Last, First, Middle Initial MM DD YY

Social Security Number __ __ __-__ __-__ __ __ __ _____
Place of Birth

Parent/ Guardian _____, _____ _____
Last Name First, Middle Initial Relationship to Child

Parent/ Guardian _____, _____ _____
Last Name First, Middle Initial Relationship to Child

Contact Information

Street Address _____ Apt # _____

City _____ Zip Code _____

Home Phone (_____)_____ Cell Phone (_____)_____

Work Phone (_____)_____ Pager (_____)_____

Medical Provider
Does your child have a regular doctor? ☐ Yes ☐ No

Doctor's Name _____

Doctor's Phone (____) _____

Child Care
Does your child attend day care? ☐Yes ☐ No

Contact person: _____

Address of day care? _____

Phone number? (____)_____

Does your child care provider administer asthma medication to your child? ☐Yes ☐ No

may we contact your child care provider? ☐Yes ☐ No

Emergency Contact:

_____ (____)_____
Name Phone Number

Appendix D

State Interview form
(Childhood Asthma Initiative Child/Caregiver Interview Version 6.1)

This is a state-initiated form and needs to be filled out completely. The answers to this form are going to create the data about our program. Read the instructions in the box, some of the information needs to be gathered only once the rest is gathered every 6 months and at discharge.

Childhood Asthma Initiative
Parent/Guardian Interview (version 6.1)

A. Interview Date		*B. ID Numbers*	
Date of this interview:	/ / (mo./day/year)	Contractor ID (2-digit number)	A ☐☐
☐1 Enrollment interview ☐3 Discharge interview		Asthma Coordinator ID (2-digit number)	☐☐
☐2 6-month follow-up ☐4 End-of-the-Project		Child ID (3-digit number).....	☐☐☐

C. First Interview Only

a. Did a doctor or health care provider ever tell you that your child has asthma?
☐1 Yes ☐2 No

b. How were you referred to this program? *(check all that apply)*
☐1 Your doctor/nurse
☐2 Asthma Treatment Service
☐3 Child care provider
☐4 Community agency/organization
Name: _____
☐5 Flyer, newspaper, friend
☐6 Hospital (including Emergency Department)
☐7 Other: _____

c. Child's gender ☐1 Male ☐2 Female

d. Birth date / / (mo./day/year)

e. Is the child of Hispanic descent? ☐1 Yes ☐2 No

f. Please specify which of the following best describes your child's race *(choose only one)*.
☐1 Black ☐2 White ☐3 Asian/Pacific Islander
☐4 American Indian, Eskimo, Aleut
☐5 Other: _____

g. If your child is Asian/Pacific Islander, specify which of the following best describes the child (*choose only one*).
☐11 Cambodian ☐12 Chinese ☐13 Filipino
☐14 Guamanian ☐15 Hawaiian ☐16 Hmong
☐17 Indian (Asian) ☐18 Japanese ☐19 Korean
☐20 Laotian ☐21 Samoan ☐22 Vietnamese
☐23 Other: _____

SECTION D. HEALTH CARE ACCESS

1. (***Only for program participants in Alameda, Los Angeles [Little Lungs], and San Diego***) Are you currently enrolled in the Asthma Treatment Service (ATS)?

☐ 1 Yes, ID#_____ ☐ 2 No ☐ 9 Don't know

2. Does your child have any kind of health care coverage including health insurance, prepaid plans such as HMOs (health maintenance organizations) or government plans like Medi-Cal and Healthy Families?

☐ 1 Yes (*answer Q.2a and 2b*) ☐ 2 No (*skip to Q.3*)

2a. What kind of health care coverage is this?

☐ 1 Private health insurance including HMO
☐ 2 Medi-Cal or Medicaid
☐ 3 Healthy Families Program
☐ 4 California Kids Program
☐ 5 Other [specify]: _____
☐ 8 Refused
☐ 9 Don't know

2b. About how long has your child had this health care coverage?

☐ 1 Less than 6 months
☐ 2 6 months or longer, but less than 12 months
☐ 3 12 months or longer
☐ 9 Don't know/Not sure

3. Do you usually take your child to the same doctor or clinic for his/her health care?

☐ 1 Yes (Clinic name: _____) ☐ 2 No

SECTION E. ASTHMA SYMPTOMS

4. In the past 2 weeks, how often has your child had DAYTIME coughing, wheezing, or shortness of breath?

- ☐ 1 2 times a week or less
- ☐ 2 More than 2 times a week, but not every day
- ☐ 3 Every day, but not all the time
- ☐ 4 Every day, all the time

5. In the past 2 weeks, how many NIGHTS has your child been bothered by coughing, wheezing, or shortness of breath?

- ☐ 1 Once every 2 weeks or less
- ☐ 2 Once a week
- ☐ 3 More than once a week
- ☐ 4 Frequently/every night

6. How many times has your child been seen in the emergency room or urgent care center because of cough, wheezing or shortness of breath from his/her asthma?

In the past 6 months
_____ times
In the past 12 months
_____ times

7. How many times has your child been admitted to a hospital overnight because of his/her asthma?

In the past 6 months
_____ times
In the past 12 months
_____ times

8. Besides those emergency room/urgent care center visits (Q.6), how many times has your child been seen in the doctor's office or clinic for urgent treatment of worsening asthma symptoms?

In the past 6 months
_____ times
In the past 12 months
_____ times

9. Does your child have more trouble with asthma during certain times of the year?

☐ 1 Yes *(answer Q.9a)* ☐ 2 No *(skip to Q.10)*

9a. During which season does your child have more trouble? *(mark all that apply)*

☐ 1 January ☐ 2 February ☐ 3 March ☐ 4 April ☐ 5 May ☐ 6 June
☐ 7 July ☐ 8 August ☐ 9 September ☐ 10 October ☐ 11 November ☐ 12 December

10. In the past 4 weeks, how many work or school days have you or another adult caregiver missed because of your child's asthma?

_____ days

SECTION F. ASTHMA MEDICATION

11a. During the past **12 months**, has your child been prescribed any asthma medications?	☐$_1$ Yes (In table below, mark medications, provide *prescribed* dose information) ☐$_2$ No
11b. During the past **4 weeks**, has your child been taking any asthma medications?	☐$_1$ Yes (In table below, mark medications, provide *actual* dose information) ☐$_2$ No

Medication Generic Name (*brand name*)	**Prescribed Dose**			**Actual Dose as taken**		
	# of puffs, mg, cc (ml) each time	# of times/day	# of days/week	# of puffs, mg, cc (ml) each time	# of times/day	# of days/week
<Long-term control medications >	*Circle puff, mg, or cc*			*Circle puff, mg, or cc*		
☐ Cromolyn sodium (*Intal*) ☐ Nebulizer	puff • mg • cc			puff • mg • cc		
☐ Nedcromil sodium (*Tilade*)	puff • mg • cc			puff • mg • cc		
☐ Beclomethasone dipropionate (*Beclovent, Vanceril, Qvar*)	puff • mg • cc			puff • mg • cc		
☐ Budesonide (*Pulmicort, Pulmicort Turbuhaler, Pulmicort Respules*) ☐ Nebulizer	puff • mg • cc			puff • mg • cc		
☐ Flunisolide (*AeroBid*)	puff • mg • cc			puff • mg • cc		
☐ Fluticasone propionate (*Flovent*)	puff • mg • cc			puff • mg • cc		
☐ Triamcinolone (*Azmacort*)	puff • mg • cc			puff • mg • cc		
☐ Salmeterol (*Serevent, Serevent Diskus*)	puff • mg • cc			puff • mg • cc		
☐ Sustained-release albuterol (*Volmax, Proventil Repetabs*)	puff • mg • cc			puff • mg • cc		
☐ Theophylline (*Aerolate, Choledyl, Slo-bid, Theo-dur, Slophyllin*)	puff • mg • cc			puff • mg • cc		
☐ Montelukast (*Singulair*) – Leukotriene modifier	puff • mg • cc			puff • mg • cc		
☐ Zafirlukast (*Accolate*) – Leukotriene modifier	puff • mg • cc			puff • mg • cc		
Other long-term control medications Name: ☐$_1$ Inhaler ☐$_2$ Nebulizer ☐$_3$ Tablet ☐$_4$ Other	puff • mg • cc			puff • mg • cc		

Medication Generic Name (*brand name*)	Prescribed Dose			Actual Dose averaged over the past 4 weeks		
	# of puffs, mg, cc (ml) each time	# of times/day	# of days/week	# of puffs, mg, cc (ml) each time	# of times/day	# of days/week
<Quick-relief medications >	*Circle puff, mg, or cc*			*Circle puff, mg, or cc*		
☐ Albuterol (Ventolin, Proventil, Airet) ☐ Nebulizer	puff • mg • cc			puff • mg • cc		
☐ Bitolterol (*Tornalate*)	puff • mg • cc			puff • mg • cc		
☐ Metaproterenol (*Alupent*)	puff • mg • cc			puff • mg • cc		
☐ Levalbuterol (*Xopenex*)	puff • mg • cc			puff • mg • cc		
☐ Pirbuterol (*Maxair*)	puff • mg • cc			puff • mg • cc		
☐ Ipratropium bromide (*Atrovent*)	puff • mg • cc			puff • mg • cc		
Other quick-relief medications Name: ☐$_1$ Inhaler ☐$_2$ Nebulizer ☐$_3$ Other	puff • mg • cc			puff • mg • cc		
<Other>	*Circle puff, mg, or cc*			*Circle puff, mg, or cc*		
☐ Methylprednisolone (*Medrol*)	puff • mg • cc			puff • mg • cc		
☐ Prednisolone (*Prelone, Prediapred*)	puff • mg • cc			puff • mg • cc		
☐ Prednisone (*Deltasone, Intensol*)	puff • mg • cc			puff • mg • cc		

12. Does your child use a spacer for taking inhaled medications?	☐$_1$ Yes ☐$_2$ No

SECTION G. ASTHMA MANAGEMENT PLAN

13. Do you have a written plan for managing your child's asthma (often called "Asthma Management Plan" or "Asthma Action Plan")?

☐ 1 Yes (*answer Q.13a, 13b, 13c*) ☐ 2 No (*skip to Q.14*)

13a. When did you get it?	13b. Does the plan include instructions on what to do with asthma attacks or exacerbation (i.e., when symptoms worsen)?	13c. Does the plan include instructions on how to prevent worsening of asthma symptoms or instructions about long-term control?
☐ 1 Within the last 6 months ☐ 2 More than 6 months, but less than 12 months ago ☐ 3 More than 12 months ago	☐1 Yes ☐2 No	☐1 Yes ☐2 No

14. Did your child receive an influenza (flu) vaccination in the past 12 months?

☐ 1 Yes ☐ 2 No ☐ 8 Refused ☐ 9 Don't know

15. Did your doctor, other healthcare provider, or your Asthma Coordinator give you advice about how to prevent your child's asthma symptoms in the following areas?		(*If "Yes"*) Have you been able to follow the advice?			
		All of the time	Most of the time	Some of the time	Not at all
a. Child should take medicines regularly	☐1Yes ☐2No	☐1	☐2	☐3	☐4
b. Demonstrated how to take medicines	☐1Yes ☐2No	☐1	☐2	☐3	☐4
c. Child should avoid tobacco smoke	☐1Yes ☐2No	☐1	☐2	☐3	☐4
d. Other _____	☐1Yes ☐2No	☐1	☐2	☐3	☐4
e. Other _____	☐1Yes ☐2No	☐1	☐2	☐3	☐4
f. Other _____	☐1Yes ☐2No	☐1	☐2	☐3	☐4

SECTION H. ENVIRONMENT

16. Is your child in a child care center, a family child care home, or preschool? If your child is in one of these places, on average how many hours per week does your child spend there the past **4 weeks**?

☐1 Yes, child care center/family child care home/preschool ___ hours per week (*answer Q.16a*)

☐2 No. (*skip to Q.17*)

16a. In the past **4 weeks**, how many days of child care or preschool has your child missed because of asthma? _____ days

17. In the past **4 weeks**, in your house and in your car, how often do you think your child was exposed to tobacco smoke?

☐ 1Every day ☐ 2Once or twice a week ☐ 3Rarely ☐ 4Never

18. In the past **4 weeks**, in the house of relatives or neighbors, how often do you think your child was exposed to tobacco smoke?

☐ 1Every day ☐ 2Once or twice a week ☐ 3Rarely ☐ 4Never

SECTION I. QUALITY OF LIFE *(at enrollment and at exit)*

- If two or more adult caregivers are present, only one primary caregiver should answer the questions.
- Preferably, the same adult caregiver answers the questions at enrollment and discharge.
- Mark only one box for each question.

19. What is your relationship to the child.	☐1 Mother, stepmother, or foster mother ☐3 Grandmother ☐5 Aunt ☐2 Father, stepfather, or foster father ☐4 Grandfather ☐6 Uncle ☐7 Other (*specify*) _____
20. What is your age?	_____ years old

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
21. During the past **4 weeks**, how often did you feel helpless or frightened when your child experienced cough, wheeze, or breathlessness?	☐1	☐2	☐3	☐4	☐5
22. During the past **4 weeks**, how often did your family need to change plans because of your child's asthma?	☐1	☐2	☐3	☐4	☐5
23. During the past **4 weeks**, how often did you feel frustrated or impatient because your child was irritable due to asthma?	☐1	☐2	☐3	☐4	☐5
24. During the past **4 weeks**, how often were you awakened during the night because of your child's asthma?	☐1	☐2	☐3	☐4	☐5
	Very worried or concerned	Fairly worried or concerned	Somewhat worried or concerned	A little worried or concerned	Not worried or concerned
25. During the past **4 weeks**, how worried or concerned were you about your child's asthma medications and side effects?	☐1	☐2	☐3	☐4	☐5

CHECK ITEMS AT DISCHARGE

To Asthma Coordinator: Please confirm the following minimum discharge criteria have been met. Refer to *Instructions for Completing the Parent/Guardian Interview* for the minimum discharge criteria.

☐1 Child has a "medical home" (see Q.3)

☐2 Child's asthma condition is under control (see Q.4 and 5)

☐3 Child has a written asthma management plan (see Q.13)

☐4 Child has health care coverage (see Q.2)

Appendix E

Additional Interview

This interview contains questions that we thought were relevant to our data collection but was not included on the state initiative. They could be done right after the state questions the family does not have to know they are a different form. If the family seems restless you should wait until your next visit.

Name_____

Case #_____

Date _____

ASTHMA START ADDITIONAL INTERVIEW FORM

What triggers your child's asthma?

☐ Tobacco Smoke	☐ Weather	☐ Pollution
☐ Perfumes	☐ Illnesses	☐ Dust/ pests
☐ Pets/ Animals	☐ Exercise/ Physical Play	☐ Strong Emotions
☐ Mold	☐ Respiratory Infections	☐ Uncertain

Capacity to Manage Asthma

How confident do you feel managing your child's asthma?

☐ Very Confident
☐ Somewhat confident
☐ Not confident
☐ No confidence

What do you think is standing in the way of managing your child's asthma more effectively?

How knowledgeable do you feel about asthma and its causes?

☐ Knowledgeable about asthma
☐ Somewhat knowledgeable
☐ Little knowledge

What types of information would increase your knowledge and allow you to manage your child's asthma more effectively?

☐ Triggers
☐ Medications
☐ Warning Signs
☐ Other_____

Are there other persons whom you would want to receive information about asthma management?

Do you have family or friends who provide support to you when your child is having an asthma episode?

☐Yes ☐ No

Does your child enter or visit other homes where there is smoking? ☐Yes ☐ No

Appendix F

Home assessment

As stated in the procedures this for is to be completed in a respectful manner. Commenting on a person's housecleaning skills is a delicate matter. Make sure to remind them you are doing this to keep the child healthy and not to judge them.

A copy of this form is to be left with the family. If we do not yet have the forms created in duplicate quickly write out a copy for you or bring carbon paper. It is important they have a form to look at. Information from this form will be used to create the family goals worksheet.

ASTHMA AT HOME

Asthma Coordinator:_____ Name:_____

Asthma Coordinator #: _____ ID#: _____

Date:_____

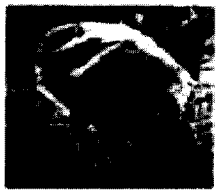
	Good Job	Needed	
MEDICATIONS 	❑	❑	Keep action plan and medications in an easy to find and safe place.
	❑	❑	Wash spacer and mask weekly.
	❑	❑	Make sure nebulizer is working properly.
	❑	❑	Refill medications before you run out.
SMOKE 	❑	❑	Do not smoke. Attend classes to help stop smoking.
	❑	❑	Do not allow smoking in the home or car.
	❑	❑	If you smoke, smoke outside / change clothes before returning.
DUST 	❑	❑	Vacuum weekly with high efficiency filter or central vacuum. Make sure your child is not home when vacuuming.
	❑	❑	Remove carpet if possible.
	❑	❑	Wet mop floors and wipe surfaces weekly.
	❑	❑	Wash sheets, blankets, stuffed toys in hot water every 1-2 weeks.
	❑	❑	Cover mattresses and pillows in dust proof zippered covers.
	❑	❑	Reduce clutter and remove stuffed animals.
	❑	❑	Clean heaters regularly.
COCKROACHES/ RODENTS 	❑	❑	Do not leave food or garbage out. Store food in airtight containers.
	❑	❑	Try using poison baits, such as boron compounds. Vacuum up cockroach remains.
	❑	❑	Fix leaky plumbing or other sources of water. Use sealants.
MOLD 	❑	❑	Use a fan or open a window when showering or cooking.
	❑	❑	Clean mold with mild detergent.
	❑	❑	Fix leaky plumbing or other sources of water. Use sealants.
ANIMALS 	❑	❑	Consider not having pets. Keep pets out of your child's bedroom
	❑	❑	Wash your and your child's hands after petting animals.
ODORS/SPRAYS 	❑	❑	Do not use perfume, talcum powder, incense, or other strong scents.
	❑	❑	Do not use stove for heating.
	❑	❑	When cleaning, keep child away and don't use strong smelling cleansers.

ASTHMA EN EL HOGAR

Cordinador de Asma: _____ Nombre: _____

Coordinador de Asma #: _____ ID#: _____

Fecha: _____

	Buen Trabajo	Necesita Trabajo	
MEDICAMENTOS 	❑	❑	Tenga el Plan de Acción para el Asma en un lugar fácil de encontrar.
	❑	❑	Lave el Espaciador y la Mascarilla cada semana.
	❑	❑	Asegure que el Nebulizador este trabajando.
	❑	❑	Rellene los medicamentos antes de que se acaben.
HUMO DE TABACO 	❑	❑	Participe en un programa para dejar de fumar.
	❑	❑	No permite que alguien fume en su casa o en el carro.
	❑	❑	Si usted fuma, fume afuera.
POLVO Y ARANITAS DE POLVO 	❑	❑	Use la aspiradora una vez por semana
	❑	❑	Si es posible, no tenga el piso alfombrado.
	❑	❑	Lave los pisos cada semana.
	❑	❑	Lave las sabanas, cubrecamas, y juguetes de peluche cada semana.
	❑	❑	Use fundas que no permiten el paso del polvo para las almohadas y el colchón.
	❑	❑	Reduzca desorden.
	❑	❑	Pase un paño húmedo a las salidas del aire de la calefacción.
CUCARACHAS 	❑	❑	No deje alimentos ni basura afuera.
	❑	❑	Cubra todos los alimentos.
	❑	❑	Use trampas de gelatinas para eliminar las cucarachas.
	❑	❑	Repare las gotas de agua y mantenga secas y limpias estas zonas (llaves de agua).
MOHO 	❑	❑	Cuando se bañe o este cocinando abra las ventanas o use un ventilador para eliminar la humedad.
	❑	❑	Limpie el mojo con un limpiador antibacteriano.
	❑	❑	Repare las gotas de agua y mantenga secas y limpias estas zonas
ANIMALES 	❑	❑	No deje que los animales estén en los dormitorios del niño(a).
	❑	❑	Lave las manos de su niño(a) después que toquen los animales.
OLORES/SPRAYS 	❑	❑	No use perfume, polvo de talco, incienso, o otros productos con olores fuertes.
	❑	❑	No use su hornillo para calentar la casa.
	❑	❑	Cuando este limpiando, haga que los niños con asma salgan del cuarto.
	❑	❑	No use limpiadores con olores fuertes.

Appendix G

In-Home Recommendations

This is a tool to keep track of the family's progress in correcting some of the triggers in their home. This is a more detailed version of the home assessment. This form is done by the AC and not given to the family. It is all right if the family sees this form but it remains in their file. The AC should fill this out after each visit and put the date on the top of each column. Use only one code for each square. Please note the codes are different for first visits and follow-up visits.

Case #_____

In Home Recommendation Tracking

Recommendations	Dates of Follow-up Visits: First					AC Action
MEDICATIONS						
Keep Action Plan and meds in easy to find place						
Wash spacer & mask weekly						
Make sure nebulizer is working						
Refill Medications before you run out						
SMOKING						
Do not smoke						
Attend smoking cessation classes						
Do not allow smoking in house or car						
Smoke outside and change clothes						
DUST						
Vacuum weekly with HEPA vacuum						
Vacuum when child is not home						
Remove carpet if possible						
Wet mop floors weekly						
Wash bedding, stuffed animals in hot water every 2 weeks						
Cover mattresses and pillows						
Reduce Clutter and remove stuffed animals						
Replace heating system filters regularly						
COCKROACHES						
Do not leave food or garbage out						
Store food in air tight containers						
Use boric acid						
Fix leaky plumbing and other water sources						
MOLD						
Open window when showering/ cooking						
Clean mold with mild bleach solution						
Fix leaky plumbing and other water sources						
ANIMALS						
Keep pets out of child's bedroom						
Wash hands after petting animals						
ODORS/SPRAYS						
Don't use perfume, talcum, incense						
Do not use stove for heating						
When cleaning, keep child away from strong smelling cleansers						

First G= Good
N= Needed
N/A =Not applicable

F- up C= completed
S= Started not complete
T= No Action taken
D= Did not follow – up

Asthma Coordinator Action B= Provided Bedding
V= Vacuum provided
P= provided other _____

07/10/01

Appendix H

Tracking form

This form helps the worker keep track of the educational needs of the family. This form is done after the visit from observation and is not given to the family. Be sure to fill out a column for each visit. On the last row there is a space for visit type on each day. There is a key for visit types.

Choose only one choice from the education key that describes how they are doing on each topic.

1= Verbalizes knowledge/demonstrates skills. Someone in this category would be confident in his or her answers. They would get 80% or better on a quiz about asthma. They would be very familiar with their children's medications and how to maintain the medical equipment.

2= needs reinforcement. A parent in this category would have some knowledge of asthma but was not very confident. They may get medications confused or they may not be aware of what triggers their child's asthma. They may score between 50-80% on a quiz about asthma.

3= caregiver has no knowledge. A caregiver in this category does not understand their child's asthma at all. They need basic education on this topic. They may score below 40% on a quiz about asthma.

4= No education given by coordinator. The asthma coordinator will indicate a 4 in the box if no education in this category was provided on that day. Asthma coordinators use tracking form to plan education topics for family.

This form will be used by the asthma Start evaluator to assess knowledge change of families participating in Asthma Start program. This information will be shared with the state to identify number of activities performed.

Before a family graduates the asthma coordinator will want to cover each educational topic. By the time the family graduates they should be able to verbalize knowledge on all the topics

Also complete the sections on the bottom pertaining to childcare and medical visits. This information will also be share with the state.

Case #

Tracking Form

Child's Name _____, _____ DOB ____/____/____

Basic Facts about asthma	Date						
a. Asthmatic vs. normal airways							
b. What is an asthma attack							
c. Well controlled asthma							
d. Resources							
Roles of medicines							
a. How medicines work							
b. Controller medications							
c. Quick relief medications							
Skills							
a. Inhaler and spacer use							
b. Recognition of danger signs							
c. Deep breathing and relaxation							
Asthma Action Plan							
a. responding to changes in severity							
b. Zones							
c. When to seek medical attention							
Triggers							
a. concept of triggers							
b. Remediation							
Visit type							

Education Key (choose one only)
1= Verbalizes knowledge/demonstrates skills
2= Needs reinforcement
3= Caregiver has no knowledge
4= No education given by coordinator

Visits
H = Home Visit
O = Office Visit
C = Child Care
T = Telephone
M = Medical Provider

Child Care Visit Date ___/___/___
☐ Parent refused
☐ Provider refused/ Unable to contact
☐ Met with provider
☐ Met with provider and family
☐ Sent information
☐ Provided Counseling
☐ Referred to trainings
☐ Provided walk through Assessment
☐ Not in childcare

Medical Visit Date ___/___/____
☐ Parent refused
☐ Provider refused/ Unable to contact
☐ Met with provider
☐ Met with provider and family
☐ Sent information
☐ Provided Asthma Management Plan
☐ No provider

Appendix I

Family Goals Worksheet

Working with the family, the Asthma Coordinator develops a family service plan including goals set by the family and a step-by-step plan for reaching those goals. The Asthma Coordinator and the family share responsibility for ensuring that the plan is carried out. The Asthma Coordinator and the family jointly assess progress toward the service plan goals at each home visit. The Family Service Plan is revised as needed to reflect new goals and/or barriers or obstacles encountered by the family.

An example of a completed goals worksheet is included. These goals should be gathered from the home assessment, additional interview form and tracking forms. These goals should be the family's goals. You should ask the family what they think the steps should be. You can also provide feedback if they are not sure. If you are working on something difficult like smoking, you can ask them what they want do they accomplish. Remind them they can make small obtainable steps for themselves. We want this to be a tool that helps the client. We want this to be their goals.

You should work across when filling out this form. Start with the first goal. This goal should be simple and something that can be reached in the next few months. Then you should fill out the steps needed for this goal. You can number the steps in the box. You will probably have several steps to each goal. Then you should indicate who will do each step. You can write expected date. This gives people a deadline and it encourages them not to put it off. We do not give them consequences for not following through by the certain date. At a follow –up visit you can fill out the outcome if appropriate. You can use two pages for goals but is good not to overwhelm someone with to many things to do in one visit.

IMPORTANT: They should get a copy of this that day or as soon as possible.

Child's Name_____

Family Goals Worksheet

Date: July 15, 2001

Goal	Steps Needed	By Whom	Date Expected	Outcome
1.To eliminate smoking in the house.	1. Choose a jacket or large shirt to put over clothes when outside. 2. Only smoke outside w/ jacket on remove jacket and keep outside before re-entering house. 3. Amy will provide literature and referrals for stopping smoking.	mom mom Amy	August 1 August 15 July 18	completed completed completed
2. To get child on insurance	1. Amy will bring application for Healthy Families. 2. Mom will look for child's birth certificate. 3. Mom and Amy will fill out form and Amy will take to the appropriate agency	Amy Mom Mom & Amy	July 18 July 18	completed completed completed
3.				

Child care Visit to be arranged: ☐ **Yes** ☐ **No** **By when** ____/____/____

Provider Visit to be arranged: ☐ **Yes** ☐ **No** **By when** ____/____/____

Parent/Guardian Name: _____Signature:_____

Asthma Coordinator Name:_____Signature:_____

Child's Name_____

Date:

Family Goals Worksheet

Goal	Steps Needed	By Whom	Date Expected	outcome
1.				
2.				
3.				

Child care Visit to be arranged: ☐ **Yes** ☐ **No** **By when** ____/____/____

Provider Visit to be arranged: ☐ **Yes** ☐ **No** **By when** ____/____/____

Parent/Guardian Name: _____Signature:_____

Asthma Coordinator Name:_____Signature:_____

Appendix I

Progress Notes

The date goes on the far left of the paper. Date each entry. Sign each entry, with your name and title. These are notes the Asthma coordinators write in narrative form to record what happened in the visit. Record what you observed and what the parents said. Try to stay objective. Do not write things that you assume as if they were fact. The coordinator should also record other work that is done for the family in the progress notes. If phone calls are made on the family's behalf they should be recorded as well as the outcome.

Record if the family is not home when you come for appointments. Also record your reminder calls or other correspondences.

If you make a mistake put one line though it and initial it. Do not use white-out.

Remember: A person always has the right to look in their file if they request it. Do not write anything you would not want them to read.

Asthma Start Progress Notes

te

Child Name_____

Case #_____

DOB_____

Appendix K

Case Closing Form

When a family reaches the goals mentioned in the Handbook and all of their goals they developed on their goal worksheet their case can be closed. Please check one from the top category and as many as apply from the next category.

If you have to close the case before they meet most of the goals, please explain why. This form needs to be submitted to the director of the program before you can officially close the case.

Case Closing

Child's Name _____
Date of Birth_____
Date of Last Visit_____

Reason for Closing:

___Completed program
___Relocated out of catchments area
___Voluntary departure
___Death
___Other

Please check as many as apply:

___No hospitalizations or emergency department visits for asthma in three months
___No child care absences due to asthma in the past month.
___Child has one specific asthma doctor (primary care or specialist).
___Child has medical insurance.
___Child has an Asthma Action Plan filled out by the child's asthma doctor.
___Child has appropriate preventive medications and takes them appropriately.
___Child has, and knows how to use, a peak flow meter and spacer (age appropriate).
___Family has reduced indoor asthma triggers.
___Family has become self reliant in accessing needed supportive services
___(other markable accomplishments)_____.

Comments_____
_____
_____
_____

_____	_____	_____
Asthma Coordinator (print)	Signature	Date
_____	_____	_____
Program Director (print)	Signature	Date

Appendix L

Follow-up phone interview

Appendix M

Chart Checklist

This form is mainly to assist the coordinator. This form has all the forms listed and what order they go in the chart. This form also has a small box next to each form so the coordinator can check it off when they complete it.

Name_____
ID#_____

Asthma Start
Check list - chart order

Items are listed top to bottom. The listing below is what a chart will look like when it is closed. Closing or update paperwork does not have to be included until the appropriate time.

Flap 1

❑ Registration	Done w/ family
❑ Consent for release of information	Done w/ family & given to family
❑ State closing form	Done w/ family
❑ State Interview 6 Month Update	Done w/ family
❑ State Interview Form	Done w/ family
❑ Additional Interview	Done w/ family
❑ Referral Form (CHDP, Children's etc)	If applicable
❑ Checklist/Chart Order	Done by worker

Flap 2

❑ Tracking (knowledge based)	Worker observation
❑ In-Home Recommendations	Worker observation
❑ Asthma Quiz (optional)	Done w/ Family

Flap 3

❑ Progress Notes (most recent on top)	Worker observation

Flap 4

❑ Phone follow-up	Done w/ family
❑ Case Closing Form	Done w/ family
❑ Family Goals	Done w/ Family & given to family
❑ Home Assessment	Done w/ family & given to family

Flap 5
Correspondences & Miscellaneous

Flap 6
❑ Asthma Management plan — Done by medical provider
Other medical reports